STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

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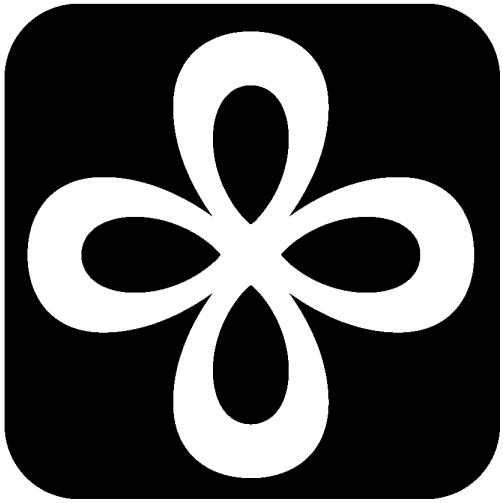

Provider Manual

Psychologist Services

CHAPTER E: COVERAGE AND LIMITATIONS Page

CHAPTER F: BILLING AND PAYMENT

APPENDIX

I. PSYCHOLOGISTS ELIGIBLE TO PARTICIPATE

All psychologists licensed to practice in the state of Iowa or other states and meeting the standards of the National Register of Health Service Providers in Psychology are eligible to participate in the Medicaid program.

Criteria for listing in the National Register are as follows:

A. Currently licensed or certified by the state board of examiners for psychology at the independent practice level of psychology.

B. A doctorate degree in psychology from a regionally accredited educational institution.

C. Two years of supervised experience in health service, of which at least one year is postdoctoral and one year (may be postdoctoral year) is in an organized health service training program.

To qualify, internships must meet all the criteria required by the American Psychological Association, as follows:

1. An organized training program, in contrast to supervised experience or on-the-job training, is designed to provide the intern with a planned, programmed sequence of training experiences. The primary focus and purpose is assuring breadth and qualify of training.

2. The internship agency had a clearly designated staff psychologist who was responsible for the integrity and quality of the training program and who was actively licensed or certified by the state board of examiners in psychology.

3. The internship agency had two or more psychologists on the staff as supervisors, at least one of whom was actively licensed as a psychologist by the state board of examiners in psychology.

4. Internship supervision was provided by a staff member of the internship agency or by an affiliate of that agency who carried clinical responsibility for the cases being supervised. At least half of the internship supervision was provided by one or more psychologists.

5. The internship provided training in a range of assessment and treatment activities conducted directly with patients seeking health services.

6. At least 25% of trainee's time was in direct patient contact (minimum 375 hours).

7. The internship included a minimum of two hours per week (regardless of whether the internship was completed in one year or two) of regularly scheduled, formal, face-to-face individual supervision with the specific intent of dealing with health services rendered directly by the intern.

   There must also have been at least two additional hours per week in learning activities such as: case conferences involving a case in which the intern was actively involved, seminars dealing with clinical issues, cotherapy with a staff person including discussion, group supervision, additional individual supervision.

8. Training was post-clerkship, post-practicum and post-externship level.

9. The internship agency had a minimum of two interns at the internship level of training during applicant's training period.

10. The trainee had title such as “intern,” “resident,” “fellow,” or other designation of trainee status.

11. The internship agency had a written statement or brochure which described the goals and content of the internship, stated clear expectations for quantity and quality of trainee’s work and was made available to prospective interns.

12. The internship experience (minimum 1500 hours) was completed within 24 months.

Psychologists who are not listed in the National Register but who feel they meet those qualifications should present their credentials to the Medicaid fiscal agent. A questionnaire must be completed to establish that National Register standards are met.

Psychologist must be independently practicing and not employed by a physician, hospital, community mental health center, or other entity.

II. COVERAGE OF PSYCHOLOGIST SERVICES

With the cooperation and advice of the Iowa Psychological Association, the Department has established standards governing service for which payment will be made and formulated policies and procedures to be followed.

Payment will be approved for services as authorized by state law when they are provided by the psychologist in the psychologist’s office, a hospital, nursing, or residential care facility.

Payment shall be made only for time spent in face-to-face consultation with the client. No payment will be made for services rendered by employees of the psychologist or for services not rendered personally by the psychologist.

A. Covered Services

Coverage is generally limited to psychotherapy and psychological examinations in the office setting. However, payment will be made for covered procedures necessary to maintain continuing treatment during periods of hospitalization or convalescence for a physical illness.

Payment will also be made for procedures provided within a hospital, day hospital, nursing facility or residential care facility as part of an approved plan of treatment when a psychologist is not employed by the facility.

1. Psychotherapy

   Payment will be approved for the following:

   a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period; or

   b. Couple, marital, family or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period; or

   c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

2. Psychological Examinations

   Payment will be approved for psychological examination and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress not to exceed eight hours in any 12-month period.

Medicaid recipients and applicants entering nursing homes (ICF and SNF) are screened by the Iowa Foundation for Medical Care (IFMC) to determine if the person has a need related to mental illness, mental retardation, or a related condition (developmental disability). This is a Level I screening.

If the person has such needs, the IFMC requires a further evaluation before Medicaid will pay the nursing home care. This Level II evaluation shall specifically identify the needs of the resident, so the facility can develop a plan to meet the resident's needs. This examination is payable even if the recipient has already received eight hours of examination and testing.

These procedures are part of the Health Care Financing Administration's Preadmission Screening and Annual Resident Review (PASARR) requirements.

3. Mileage

Payment will be approved for mileage when the following conditions are met:

a. It is necessary for the psychologist to travel outside of the home community, and

b. There is no qualified mental health professional more immediately available in the community, and

c. The recipient has a medical condition which prohibits travel.

B. Exclusions

Payment will not be made for the following:

1. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

2. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible or coinsurance.

3. Psychological examinations employing unusual or experimental instrumentation.

4. Individual or group psychotherapy without specification of condition, symptom, or complaint.

5. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, and psychotherapy for nonspecific conditions of distress, such as job dissatisfaction or general unhappiness.

C. Service Reviews

The Department maintains a process of review of service through the fiscal agent.

The following services are subject to review:

1. Protracted therapy, beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and may be reviewed periodically thereafter.

2. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

III. REIMBURSEMENT

The basis of payment is a schedule of maximum allowances for each procedure covered.

IV. PROCEDURE CODES AND NOMENCLATURE

Enter the procedure code, description of service, and total length of time spent with the client in field 24D of the claim form. Claims submitted without a procedure code and an ICD-9-CM or DSM IV diagnosis code will be denied. The procedure codes and descriptions are as follows:

Procedure Code	Description of Service and Limitations
W0802	Interview or examination: Psychiatric diagnostic interview examination including history, mental status, or disposition per 15 minutes. (May include communication with family or other sources or ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants may be seen in place of the patient.)
W0854	Testing of client for mental retardation
W0855	Evaluation of client for mental retardation
W0900	Mileage, one way

Nursing home preadmission, screening, and annual resident review (PASARR):

W0901	Evaluation of client with mental illness
W0902	Evaluation of client with mental retardation
W0903	Evaluation of client with a related condition
Note:	If the client falls in more than one category, use two procedure codes and prorate the time according to the condition.
96100	Psychological testing and evaluation: • Reimbursed on 15-minute time increments. • Limited to 8 hours (32 units) of service in a 12-month period.

Procedure Code	Description of Service and Limitations
W0944	Individual psychotherapy: • is reimbursed on 15-minute time increments • limit of one hour (4 units) per week • limit of 40 hours per year • if combination of services, see note below
W0917	Group therapy, per person, one hour: • is reimbursed at one unit per person per week • limit of 60 hours per year • if combination of services, see note below
W0912	Group therapy (2 psychologists) per person, one hour: • is reimbursed at one unit per person per week • limit of 60 hours per year • if combination of services, see note below
W0937	Group therapy, per person, one and one-half hour: • is reimbursed at one unit per person per week • limit of 60 hours per year • if combination of services, see note below
W0932	Group therapy (2 psychologists) per person, one and one-half hour: • is reimbursed at one unit per person per week • limit of 60 hours per year • if combination of service, see note below
W0969	Family therapy: • 15-minute units • limit of one and one-half hour (6 units) per week • limit of 60 hours per year • if combination of services, see note below
Note:	When a combination of the group, family, and individual therapy is provided, the limit is that the cost shall not exceed the allowance for 40 hours of individual therapy per year.

Procedure Code	Description of Service and Limitations
Z3	Modifier used after the procedure code when service is provided in an inpatient hospital setting
Z1	Modifier used after the procedure code when services are a result of an Early Periodic Screening, Diagnosis and Treatment (EPSDT) physical

Service will be reimbursed on the basis of time. Enter the number of units in 24F, with one unit equal to the time as shown in the description for the procedure code. (If a charge is made for mileage, enter the number of miles should be entered in 24F.)

For example, the unit for W0944 (individual psychotherapy) is 15 minutes. For W0917 (group therapy) the unit is one hour. Round units of service shall be rounded to the nearest unit. For example, 1 hour and 7 minutes is rounded to 1 hour; and 1 hour and 8 minutes is rounded to 1 hour and 15 minutes.

Payment for group therapy is based on the actual number of persons who comprise the group, but not less than six. For example, if eight persons comprise the group, payment will be based on this number. However, if the group consists of four persons, payment will nevertheless be based on six persons. The number of people in the group should be entered in 24C (description of service).

I. INSTRUCTIONS AND CLAIM FORM

A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**OPTIONAL** – Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A.
2.	PATIENT'S NAME	**REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim.

4.	INSURED'S NAME	**CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident. **Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not.
5.	PATIENT'S ADDRESS	**OPTIONAL** – Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation.
7.	INSURED'S ADDRESS	**CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4.
8.	PATIENT STATUS	**OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME	**CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program.
10.	IS PATIENT'S CONDITION RELATED TO	**CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** – No entry required.

11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29. If you have received a denial of payment from another insurance, check <u>both</u> "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** – No entry required.
14.	DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY	**CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS…	**CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required.
16.	DATES PATIENT UNABLE TO WORK…	**OPTIONAL** – No entry required.

17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	**CONDITIONAL** – Required if the referring physician does not have a Medicaid number.
17a.	ID NUMBER OF REFERRING PHYSICIAN	**CONDITIONAL*** – If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number. If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician. If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number.
18.	HOSPITALI-ZATION DATES RELATED TO…	**OPTIONAL** – No entry required.
19.	RESERVED FOR LOCAL USE	**REQUIRED** – If the patient is pregnant, write "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** – No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance. (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses.
22.	MEDICAID RESUBMISSION CODE…	**OPTIONAL** – No entry required.
23.	PRIOR AUTHORIZATION NUMBER	**CONDITIONAL*** – Enter the prior authorization number issued by Consultec.

24. A	DATE(S) OF SERVICE	**REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.
24. B	PLACE OF SERVICE	**REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – partial hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-stage Renal Disease Treatment 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility

24. C	TYPE OF SERVICE	**OPTIONAL** – No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged.
24. E	DIAGNOSIS CODE	**REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** – Enter the usual and customary charge for each line item.
24. G	DAYS OR UNITS	**REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the <u>total minutes</u> of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	EMG	**OPTIONAL** – No entry required.
24. J	COB	**OPTIONAL** – No entry required.
24. K	RESERVED FOR LOCAL USE	**CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** – No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters.

27.	ACCEPT ASSIGNMENT?	**OPTIONAL** – No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	**CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim.
30.	BALANCE DUE	**REQUIRED*** – Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	NAME AND ADDRESS OF FACILITY…	**CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered.
33.	PHYSICIAN'S, SUPPLIER'S BILLING NAME…	**REQUIRED*** – Enter the complete name and address of the billing physician or service supplier.
	GRP #	**REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider. If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line.
BACK OF FORM	NOTE	**REQUIRED** – The back of the claim form must be intact on every claim form submitted.

B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

Reserve page 9 for HCFA-1500.

Reserve page 10 for HCFA-1500.

II. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement. DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a “1” in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a “2” in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following pages.)

Reserve page 13 for Remittance Advice.

Page 14 was intentionally left blank.

C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquiries.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

B Billed charge
F Fee schedule
M Manually priced
N Provider charge rate
P Group therapy
Q EPSDT total screen over 17 years
R EPSDT total under 18 years
S EPSDT partial over 17 years
T EPSDT partial under 18 years
U Gynecology fee
V Obstetrics fee
W Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

    - Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
    - Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
    - Number of denied original claims and amount billed by provider.
    - Number of denied adjusted claims and amount billed by provider.
    - Number of pended claims (in process) and amount billed by provider.
    - Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

October 14, 1994

For Human Services Use Only

General Letter No. 8-A-AP(II)-536

Subject: Employees' Manual, Title VIII, Chapter A, Appendix, Part Two

PSYCHOLOGIST MANUAL TRANSMITTAL NO. 94-2

Subject: Psychologist Manual, Chapter E, "Coverage and Limitations," Table of Contents, page 4, revised, and page 6, revised.

The Iowa Psychological Association no longer has peer review responsibility. The reviews will be done by consultants to the Department fiscal agent.

Date Effective

December 1, 1994

Material Superseded

Remove from the Psychologist Manual, Table of Contents, page 4, dated January 1, 1994, Chapter E, page 6, dated January 1, 1994, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

October 21, 1996

For Human Services Use Only

General Letter No. 8-AP-4

Subject: Employees' Manual, Title 8, Medicaid Appendix

PSYCHOLOGIST SERVICES MANUAL TRANSMITTAL NO. 96-1

Subject: ***Psychologist Services Manual***, Table of Contents, page 4, revised; and Chapter E, *Coverage and Limitations*, page 7, revised.

This revision:

- Adds the CPT code for psychological testing. The previous code of W0729 will be discontinued.
- Adds local codes for services for mental retardation.

Date Effective

October 1, 1996

Material Superseded

Remove from ***Psychologist Services Manual***, Table of Contents, page 4, dated December 1, 1994; and Chapter E, page 7, dated September 1, 1994, and destroy them.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

January 24, 1997

For Human Services Use Only

General Letter No. 8-AP-13

Subject: Employees' Manual, Title 8, Medicaid Appendix

PSYCHOLOGIST SERVICES MANUAL TRANSMITTAL NO. 97-1

Subject: ***Psychologist Services Manual***, Chapter E, *Coverage and Limitations*, page 7, revised.

This revision clarifies that the previous code for psychological testing (W0729) is discontinued.

Date Effective

January 1, 1997

Material Superseded

Remove from ***Psychologist Services Manual***, Chapter E, page 7, dated October 1, 1996, and destroy it.

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Unisys Corporation, fiscal agent for the Iowa Department of Human Services.

IOWA DEPARTMENT OF HUMAN SERVICES
Charles M. Palmer, Director

Donald W. Herman, Administrator
DIVISION OF MEDICAL SERVICES

For Human Services use only:

General Letter No. 8-AP-63
Employees' Manual, Title 8
Medicaid Appendix

Iowa Department of Human Services

May 11, 1998

PSYCHOLOGIST SERVICES MANUAL TRANSMITTAL NO. 98-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Psychologist Services Manual***, Table of Contents (page 4), revised; and Chapter F, *Billing and Payment*, pages 1 through 17, revised.

Chapter F is revised to update billing and payment instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from the ***Psychologist Services Manual***, and destroy them:

Page	Date
Contents (page 4)	October 1, 1996
Chapter F	
1	December 1, 1993
2	Undated
3, 4	12/90
5-13	December 1, 1993
14	Undated
15, 16	10/29/93
17	11/06/93
18, 19	December 1, 1993

Additional Information

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.